MINUTES
MEETING OF
INDIGENT & CHARITY CARE AD HOC COMMITTEE
Department of Community Health, Division of Health Planning
2 Peachtree Street, 34TH Floor Conference Room
Atlanta, GA 30303

Thursday, October 21, 2004
1:00 am – 3:00 pm

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David M. Williams, MD., Chair, Presiding

MEMBERS PRESENT

Cal Calhoun
Jeffrey Crudele
Jim Connolly
Eric Randolph, MD
W. Douglas Skelton, MD
Tony Strange
Kurt Stuenkel, FACHE

MEMBERS ABSENT

Daniel DeLoach, MD
Charlotte McMullan

GUESTS PRESENT

Amr Ali, Centers for Medicare & Medicaid Services
Jennifer Bach, Gill/Balsano Consulting
Jeffrey Baxter, Nelson Mullins
Robert Bolden, Georgia Hospital Association
Brian Crevasse, Parker, Hudson, Rainer & Dobbs
Bill Evergreen, Forest
Greg Hurst, Piedmont Medical Center
Marvin Noles, Medical Center of Central Georgia
Kevin Rowley, St. Francis Hospital
Becky Ryles, Omni
Dicky Sanford, Centers for Medicare & Medicaid Services
Temple Sellers, Georgia Hospital Association
Gunther Pearson, Georgia Hospital Association
Leah Fressell Watkins, Powell Goldstein

STAFF PRESENT

Neal Childers, JD
James Connolly
Richard Greene, JD
Matt Jarrard
Isiah Lineberry (via conference call)
Rhathelia Stroud, JD
Stephanie Taylor

WELCOME AND INTRODUCTIONS

David Williams, MD, Chair, welcomed members and guests to the first meeting of the Indigent & Charity Care Ad Hoc Committee. The meeting commenced at 1:10 pm

REVIEW OF COMMITTEE CHARGE

In reviewing the committee's charge, Dr. Williams said that the Department received a wide range of input about the proposed definition of Indigent Care and Charity Care during the recent update of the Department's Proposed Administrative Health Planning Rules. He said that the Health Strategies Council has recommended the establishment of an Ad Hoc Committee to review the current definitions and to provide the Department with suggested definitions that would provide uniformity and equity for facilities concerning the calculation and reporting of indigent and charity care in the state.

Dr. Williams noted that information, which outlined definitions of indigent and charity care that are used in other states, along with the committee's Statement of Purpose was mailed to members prior to today's meeting. He said that the committee is expected to meet three times but would hold additional meetings if it is deemed necessary.

Following Dr. Williams's remarks, Kurt Stuenkel said that he disagrees with language incorporated into the committee's Statement of Purpose. He said that as long as a facility's gross charges are used in both the numerator and the denominator of the calculation for each facility, a ratio would result and this would provide a basis of comparison from facility to facility.

In response to Mr. Stuenkel's comments, Richard Greene, DHP staff, said that there are different charge structures within different hospitals and this process would not permit an adequate framework in which to make fair comparisons. He questioned whether legitimate comparisons could be made about the quantity of indigent and charity care services that are provided statewide since all providers aren't using the same definitions and processes to capture this information.

OVERVIEW OF CHALLENGES FACING THE DEPARTMENT IN THE COLLECTION OF INDIGENT AND CHARITY CARE DATA

Dr. Williams called on Mr. Greene to provide an overview of the challenges facing the Department. Mr. Greene said that there are legitimate concerns surrounding how providers around the state identify and calculate services designated as "indigent" and "charity" care. He emphasized that that this problem does not appear to be unique to the state of Georgia since research conducted by Department staff confirms that these definitions vary all around

the country. He said that the charge to the committee is to try to get this issue resolved so that providers would have a single, clear and workable standard of data reporting.

Cal Calhoun said that he would hope that the committee would not be consumed with discussing issues that are working effectively. He suggested that the committee specify the particular issue/s that need to be revisited and to deliberate on those issues only.

Mr. Crudele said that he believes that it is good public policy to move toward a more uniformed accounting system. He said that the committee should be mindful of the unintended consequences of fixing one problem while simultaneously creating another problem. He suggested that one unintended consequence could be the unnecessary penalizing of providers, since under the current CON rules a fine could be imposed if a provider did not meet specified indigent and charity care commitments. He reemphasized that any model that is selected by the committee should ensure the most optimal accounting solution.

Dr. Williams said that the committee first has to agree that there is a problem with the way that indigent and charity care data are calculated and reported to the state. He agreed with Mr. Calhoun and reiterated that the committee should spend its time only on those areas that need to be fixed and reiterated Mr. Crudele's statement about the need to be mindful of potential adverse consequences of any proposed recommendations. He said that the committee should leave today's meeting with a clear outline of the issues surrounding indigent and charity care in order to give the committee a clear sense of direction. He said that one of the challenges that the committee needs to address is how to minimize reporting errors, whether intentional or otherwise.

Neal Childers, General Council, DCH said that the need to fix the Department's definition and reporting of indigent and charity care derived from within the Department. He said that at present, providers are interpreting the Department's definitions in different ways. He said that the committee needs to develop definitions that providers can understand and will endorse so that data collection, reporting and interpretation can be done in the same manner all over the state.

Mr. Greene introduced Matt Jarrard, Statistical Unit Chief in the Division of Health Planning and called on him to provide an overview of the annual data collection and reporting process that is conducted by the Division of Health Planning via the Hospital Financial Survey and other facility surveys. Mr. Jarrard referenced handout materials that were provided in committee member packets. He indicated that the Division collects essentially the same types of basic financial values from hospitals, home health agencies, ambulatory surgery centers, and personal care homes. He said that "Charges" are used as the baseline data component from which a number of calculations are dependent. According to Mr. Jarrard, these calculations are used by the Department and the public-at-large in a variety of ways that include evaluation of performance related to indigent and charity care commitments for CON purposes and determining the financial accessibility of providers in the regulatory review

process.

Mr. Jarrard noted that current definitions taken from the Hospital Financial Survey are provided for members in today's meeting materials. He cautioned that these definitions might not be the same as those used by other state/national organizations. Also, he provided a list of facilities that have active indigent and charity care commitments, including hospitals, ambulatory surgery centers, home health centers, and personal care homes.

Members inquired about the financial reporting requirements for all Georgia hospitals. Mr. Jarrard responded that completion of the Hospital Financial Survey is required by every hospital except federal hospitals and state hospitals that do not participate in the Indigent Care Trust Fund program. He said that the survey completion process has a built-in system of checks and balances, which require certain data elements to balance throughout the survey. If particular data fields do not balance or would not be possible, electronic transmission of the survey would not be allowed. He said that the Hospital Financial Survey (and other surveys) are available electronically and can be accessed from the Department's website.

Dr. Doug Skelton inquired about whether errors in data reporting are a result of misunderstanding of reporting requirements or whether there are legitimate issues regarding the interpretation of Department standards/definitions. Department staff indicated that there may be issues in both areas but the latter may be creating the largest area of concern. Indigent Care has a clear definition, but the definition of charity care is institution-specific. Additionally, facilities that do not participate in the Indigent Care Trust Fund have more latitude to define charity care. Hospitals that participate in the Indigent Care Trust Fund use the standard definition of 235% of Federal Poverty Guidelines.

Jeff Crudele said that the committee would be remiss if it did not recognize that different providers have different abilities to provide charity care. He said that the ability to define a charity care policy, consistent with an entity or organization's needs, has some merits. He suggested that these differences are ultimately what create problems in reporting requirements. He said that if one entity decides that it is more capable of providing charity care, to a defined population and have the means to do so, that it may be very desirable to allow the provider to do so, given the current environment where there are so many uninsured and underinsured patients. He said that there should be some debate as to what income or asset level a patient has to have to pay for services and how those assets should be quantified for purposes of charity care designation. He said that providers do not want to give free care to those that have the ability to pay. Further, he said that most individual charity care policies are well thought out by local providers though they may be very inconsistent with what would be considered ideal, from a public policy perspective. He said that one of the most important aspects of this committee's deliberations will be the definition of what constitutes charity care versus what constitutes bad debt since this is an issue that the industry has struggled with for some time.

Mr. Stuenkel indicated that in the State of Georgia some facilities count charity care in a more restrictive manner while others are more expansive. He said that this is an area that the committee needs to examine. He suggested that the committee recommend a measure that would ensure flexibility but also would allow greater standardization. He said that the definition of charges is not as big an issue as this issue.

PROPOSED INDIGENT AND CHARITY CARE RULE

Mr. Greene told the ICC committee that Rob Rozier was scheduled to make a presentation and to provide an update of the Department's Proposed Health Planning Rules at today's meeting. Mr. Rozier was unable to be present but his handout materials entitled " *Department Proposed Definitions for Indigent and Charity Care Commitments*", which includes the Department's proposed definitions for indigent and charity care, are included in today's meeting packets.

Rhathelia Stroud said that some of the issues that committee members should consider during their deliberations are delineated in Mr. Rozier's submitted handout materials. (Page 5 of the document outlines the issues that are important to the Department, including the following

- When is the indigent/charity care determination made
- Determination of the percentage of Federal Poverty Levels to establish indigent income levels
- Determination of how much leeway, if any, should be granted to accommodate individual facility policies
- How to distinguish bad debt from charity care
- Use of "Charges" versus "reimbursement" in the calculation of indigent and charity care

Mr. Greene called on Jim Connolly, DCH staff to provide comments about the Indigent Care Trust Fund. Mr. Connolly said that the Department of Community Health/Division of Medical Assistance administers the Indigent Care Trust Fund (ICTF) which makes funds available to hospitals only. It is a state program that is geared to expanding Medicaid eligibility and services; support rural and other healthcare providers, primarily hospitals that serve the medically indigent and fund primary health care programs for medically indigent Georgians. ICTF is funded through voluntary intergovernmental contributions from hospital authorities affiliated with participating public hospitals, other government entities and matching federal funds. No money from Georgia's General Fund is used.

Mr. Connolly said that last fiscal year, approximately $230 million was made available, about 95 hospitals received funds; approximately 75 did not. Qualification to access funds is contingent upon the hospital's financial loss on uninsured and Medicaid patients. He said that there are some restrictions that go along with the use of these funds. He said that a substantial portion of ICTF dollars are earmarked for primary care initiatives and restricted for use to provide free or reduced free care at hospitals. One additional requirement imposed on hospitals prior to accessing ICTF dollars is the establishment of a system which ensures patient

notification about the availability of funds.

Mr. Connolly said that the Department administers a supplemental ICTF Schedule which hospitals must complete regarding the provision of indigent & charity care services. This data collection process is separate from data that is captured through the Division of Health Planning's Hospital Financial Survey. Hospitals participating in the ICTF Program must report on the trust fund services that are written off for patients under 125% of Federal Poverty Guidelines. He said that there are some things the Indigent Care Trust Fund may not cover (i.e., Medicare co-insurance,) similarly on charity care, the hospital is likely to have some significant charity care services that they have offered beyond the 200% poverty threshold. Mr. Connolly said the difference between the data needs for purposes of the Indigent Care Trust Fund and that of the Division of Health Planning is that the Certificate of Need Program, attempts to identify public need for services, while the ICTF provides significant resources to fund needed medical care.

Committee members asked about the audit requirements for hospitals receiving ICTF dollars. Mr. Connolly said that within the Medicare prescription law that passed last year, there is a requirement that the state must have an audit of the funds that have been paid out. He said that in the administration of the ICTF program, the Department utilizes data that's submitted via the Hospital Financial Survey and relies on the State Departments of Audits to help validate the data.

Mr. Calhoun said that some hospitals do not have a real incentive to account for indigent and charity care. He suggested that if a hospital were not participating in the ICTF Program, that the hospital would be less likely to put much emphasis on ensuring that patients prove that their incomes are below the indigent care level. He said that one of the goals of the committee should be to ensure a simple system that is easy to administer and one that can produce reliable and consistent data and information. He expressed concern about the committee's ability to establish tighter definitions for charity care and bad debt but not impact the data reporting system. He suggested that a system, which includes deployment of auditors and the ability to levy fines against providers, should be considered in the development of a reliable system.

PUBLIC COMMENTS

Dr. Williams called on guests to provide public comments. A representative of Draffin & Tucker said that the current definition of charity care is too restrictive. He said that any new definition should be less restrictive.

Mr. Greene and Dr. Williams thanked the guest for his remarks. They reminded members and guests that written comments could be sent to the committee and that opportunities for public comment would be offered at each committee meeting. Correspondence should be sent to Stephanie Taylor's attention at the Division of Health Planning.

CONSIDERATION OF NATIONWIDE DEFINITIONS OF INDIGENT, CHARITY CARE AND BAD DEBT

Dr. Williams reminded committee members that everyone should have received information which provided sample nationwide definitions of indigent, charity care and bad debt. He commented that he had hoped that everyone would have reviewed this document and had determined what elements of each state definitions were worthy of the committee's consideration. He said that the committee should not attempt to "reinvent the wheel" but may want to examine some of these definitions for consideration and application here in the State of Georgia.

Dr. Skelton asked about the Department's current rules. Mr. Greene said that the Department undertook a massive reorganizing and rewriting of the Health Planning Administrative Rules. The Department recommended that they be removed from Chapter 272 under the State Health Planning Agency to the Department of Community Health (DCH), Chapter 111. He said that during the review and rewriting process, changes were limited to the Administrative Rules and did not include any substantive changes to the Department's service-specific rules. The process included an extensive public hearing process. He said that information contained in member packets represents written comments that had been received by the Department and language that was originally proposed; however multiple opportunities for public input necessitated several rewrites of this proposed language.

Dr. Williams indicated that in his review of the material one state namely, Delaware had a policy regarding charity care that would allow some flexibility for providers. Delaware's state policy indicated that if one year the provider was unable to meet the commitment, it could be carried over to the next year. Another committee member noted that Florida has comprehensive documentation requirements which are worthy of committee review.

In response to a committee member's reference of documentation requirements, Mr. Crudele said that the population that is indigent is not a very compliant population with regards to information submission particularly because they are concerned that any interaction with a provider might result in collection of payment. He said that providers should not be overburdened with the amount of time and effort necessary to make a determination. He suggested that providers should have policies and procedures in place to facilitate collection activity or payment inquiry, regarding a balance or partial balance once the patient provides the defined level of acceptable documentation.

Several members asked about the Department's draft charity care definition, including the prohibition of billing for services before a financial determination is made. Also, members asked about the policy that requires providers to give prior notice of its charity care policy to patients prior to billing was discussed. Committee members asked whether the proposed

language in the Department's draft document would cause any concerns. Most members agreed that it is appropriate to include language about prior notice particularly since several states that were surveyed have systems in place to fully inform the patient of potential financial resources that might be available. Members agreed that patient communication is critical throughout this process.

Mr. Connolly said that the state of Delaware requires that a statement by a Certified Public Accountant (CPA) accompany submitted data. He indicated that this requirement has been debated for a while with the Indigent Care Trust Fund Program. He indicated that the current rules to participate in the ICTF include a requirement for attestation from an independent CPA. This requirement was recommended by a hospital representative of the Department's ICTF Advisory Committee.

Mr. Crudele commented that the data requirements and definitions in the New Jersey plan would likely involve substantial administrative costs. He questioned the cost-benefit of doing something of that nature noting that there may be more efficient accounting methodologies that could address that issue without adding enormous administrative costs.

Mr. Crudele asked whether the committee has some ability to recommend a uniform accounting system as it relates to differences in charity care policies. He referenced Hospital Corporation of America's (HCA) system which has established comprehensive policies and means tests to determine whether someone could qualify as a charity patient. HCA's policy, he said, provides an accounting methodology that would allow each provider to offer the level of charity care that they so desire, under their established charity care guidelines.

Mr. Greene said that everyone's input today has been very informative. He said that this first meeting was established as an information gathering session. He recommended that everyone submit, in writing, a list of issues and concerns. Also, members were encouraged to review the materials which outline definitions from other states for future committee discussions. Members agreed that all public comments should be sent to Stephanie Taylor by the close of business on Monday, November 1, 2004 for distribution to the committee.

Mr. Strange told committee members that he is in the homecare industry and not the hospital industry. He asked whether hospitals in Georgia, as a general rule, have trouble meeting the 3% indigent commitment? Mr. Stuenkel indicated that the 3% ICC is not relegated to all hospitals, but is rather a financial commitment that is tied to specific services that are offered by hospital and other providers. Most hospitals do not have difficulty meeting their commitments.

Mr. Strange said that most home health providers in the State of Georgia have difficulty meeting the 3% indigent and charity care commitment. He said that most home health providers are not close to meeting this 3% commitment, (not even 2%, not even 1%). He said that CON and licensure requirements restrict the types of patients that home-health providers

can see. Further, he indicated that home health providers couldn't participate in the ICTF, whereas hospitals can. He expressed concern about contributing dollars to support a system without a mechanism of providing some financial return. Mr. Strange said that Healthfield has contracts with many major healthcare facilities, including Grady Health System to take 100% of their indigent care patients that qualify for home health services. Despite this, they are still unable to meet the indigent and charity care commitment requirement.

Mr. Greene said that there have been a number of discussions about why most home health providers are unable to find indigent patients, particularly in communities where hospitals are providing care to large numbers of indigent patients. He said that this is specifically why a wide range of providers, including radiation therapy providers, home health care and other providers were invited to participate on this committee. Mr. Greene noted that the Department administers a separate survey for hospitals, home health agencies, and other providers to secure indigent and charity care data.

SCHEDULE OF UPCOMING MEETINGS

Stephanie Taylor informed committee members that Dr. Deloach, who was absent from today's meeting, indicated that Fridays would be the most convenient day for him to attend future committee meetings. Following committee discussion, it was agreed that the next two meeting dates would be as follows:

- **Friday, November 19, 2004 at 1:30 pm in the 34th Floor Conference Room**.
  This meeting will be held following the Health Strategies Council meeting.

- **Friday, December 3, 2004 at 1:00 pm.**
  This meeting is slated to be held at Southside Medical Center, 1046 Ridge Avenue, SW, Atlanta, GA 30315. Travel instructions will be mailed to members.

ADJOURNMENT

There being no further business, the meeting adjourned at 3:00 pm.
Minutes taken on behalf of Chair by Stephanie Taylor.

Respectfully Submitted,
David M. Williams, MD, Chair